110TH CONGRESS
1ST SESSION

S. 558

To provide parity between health insurance coverage of mental health benefits and benefits for medical and surgical services.

IN THE SENATE OF THE UNITED STATES

FEBRUARY 12, 2007

Mr. DOMENICI (for himself, Mr. KENNEDY, Mr. ENZI, Mr. BROWN, Mr. SMITH, Mr. FEINGOLD, Mr. COLEMAN, Mr. LAUTENBERG, Mr. WARNER, Mrs. BOXER, Ms. MURKOWSKI, Mr. AKAKA, Mr. ROBERTS, Mr. CARDIN, Mr. HATCH, Ms. CANTWELL, Ms. COLLINS, Ms. STABENOW, Ms. SNOWE, Mr. BIDEN, Mr. GRAHAM, and Mr. NELSON of Nebraska) introduced the following bill; which was read twice and referred to the Committee on Health, Education, Labor, and Pensions

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A BILL

To provide parity between health insurance coverage of mental health benefits and benefits for medical and surgical services.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Mental Health Parity Act of 2007''.

SEC. 2. MENTAL HEALTH PARITY.

(a) AMENDMENTS OF ERISA.—Subpart B of part 7 of title I of the Employee Retirement Income Security Act of 1974 is amended by inserting after section 712 (29 U.S.C. 1185a) the following:

"SEC. 712A. MENTAL HEALTH PARITY.

"(a) IN GENERAL.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits, such plan or coverage shall ensure that—

"(1) the financial requirements applicable to such mental health benefits are no more restrictive than the financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), including deductibles, copayments, coinsurance, out-of-pocket expenses, and annual and lifetime limits, except that the plan (or coverage) may not establish separate cost sharing requirements that are applicable only with respect to mental health benefits; and

"(2) the treatment limitations applicable to such mental health benefits are no more restrictive than the treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage), including limits on the frequency

of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

''(b) CLARIFICATIONS.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits, such plan or coverage shall not be prohibited from—

''(1) negotiating separate reimbursement or provider payment rates and service delivery systems for different benefits consistent with subsection (a);

''(2) managing the provision of mental health benefits in order to provide medically necessary services for covered benefits, including through the use of any utilization review, authorization or management practices, the application of medical necessity and appropriateness criteria applicable to behavioral health, and the contracting with and use of a network of providers; or

''(3) applying the provisions of this section in a manner that takes into consideration similar treatment settings or similar treatments.

''(c) IN- AND OUT-OF-NETWORK.—

''(1) IN GENERAL.—In the case of a group health plan (or health insurance coverage offered in

connection with such a plan) that provides both medical and surgical benefits and mental health benefits, and that provides such benefits on both an in- and out-of-network basis pursuant to the terms of the plan (or coverage), such plan (or coverage) shall ensure that the requirements of this section are applied to both in- and out-of-network services by comparing in-network medical and surgical benefits to in-network mental health benefits and out-of-network medical and surgical benefits to out-of-network mental health benefits, except that in no event shall this subsection require the provision of out-of-network coverage for mental health benefits even in the case where out-of-network coverage is provided for medical and surgical benefits.

''(2) CLARIFICATION.—Nothing in paragraph (1) shall be construed as requiring that a group health plan (or coverage in connection with such a plan) eliminate an out-of-network provider option from such plan (or coverage) pursuant to the terms of the plan (or coverage).

''(d) SMALL EMPLOYER EXEMPTION.—

''(1) IN GENERAL.—This section shall not apply to any group health plan (and group health insurance coverage offered in connection with a group

health plan) for any plan year of any employer who employed an average of at least 2 (or 1 in the case of an employer residing in a State that permits small groups to include a single individual) but not more than 50 employees on business days during the preceding calendar year.

''(2) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of this subsection:

''(A) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—Rules similar to the rules under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code of 1986 shall apply for purposes of treating persons as a single employer.

''(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

"(C) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

"(e) COST EXEMPTION.—

"(1) IN GENERAL.—With respect to a group health plan (or health insurance coverage offered in connections with such a plan), if the application of this section to such plan (or coverage) results in an increase for the plan year involved of the actual total costs of coverage with respect to medical and surgical benefits and mental health benefits under the plan (as determined and certified under paragraph (3)) by an amount that exceeds the applicable percentage described in paragraph (2) of the actual total plan costs, the provisions of this section shall not apply to such plan (or coverage) during the following plan year, and such exemption shall apply to the plan (or coverage) for 1 plan year. An employer may elect to continue to apply mental health parity pursuant to this section with respect to the group health plan (or coverage) involved regardless of any increase in total costs.

"(2) APPLICABLE PERCENTAGE.—With respect to a plan (or coverage), the applicable percentage described in this paragraph shall be—

''(A) 2 percent in the case of the first plan year in which this section is applied; and

''(B) 1 percent in the case of each subsequent plan year.

''(3) DETERMINATIONS BY ACTUARIES.—Determinations as to increases in actual costs under a plan (or coverage) for purposes of this section shall be made by a qualified actuary who is a member in good standing of the American Academy of Actuaries. Such determinations shall be certified by the actuary and be made available to the general public.

''(4) 6-MONTH DETERMINATIONS.—If a group health plan (or a health insurance issuer offering coverage in connections with a group health plan) seeks an exemption under this subsection, determinations under paragraph (1) shall be made after such plan (or coverage) has complied with this section for the first 6 months of the plan year involved.

''(5) NOTIFICATION.—An election to modify coverage of mental health benefits as permitted under this subsection shall be treated as a material modification in the terms of the plan as described in section 102(a)(1) and shall be subject to the applicable notice requirements under section 104(b)(1).

''(f) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits.

''(g) MENTAL HEALTH BENEFITS.—In this section, the term 'mental health benefits' means benefits with respect to mental health services (including substance abuse treatment) as defined under the terms of the group health plan or coverage.''.

(b) PUBLIC HEALTH SERVICE ACT.—Subpart 1 of part A of title XXVII of the Public Health Service Act is amended by inserting after section 2705 (42 U.S.C. 300gg–5) the following:

''SEC. 2705A. MENTAL HEALTH PARITY.

''(a) IN GENERAL.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits, such plan or coverage shall ensure that—

''(1) the financial requirements applicable to such mental health benefits are no more restrictive than the financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), including deductibles, copayments, coinsurance, out-of-pocket expenses, and an-

nual and lifetime limits, except that the plan (or coverage) may not establish separate cost sharing requirements that are applicable only with respect to mental health benefits; and

''(2) the treatment limitations applicable to such mental health benefits are no more restrictive than the treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage), including limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

''(b) CLARIFICATIONS.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits, such plan or coverage shall not be prohibited from—

''(1) negotiating separate reimbursement or provider payment rates and service delivery systems for different benefits consistent with subsection (a);

''(2) managing the provision of mental health benefits in order to provide medically necessary services for covered benefits, including through the use of any utilization review, authorization or management practices, the application of medical necessity

and appropriateness criteria applicable to behavioral health, and the contracting with and use of a network of providers; or

''(3) be prohibited from applying the provisions of this section in a manner that takes into consideration similar treatment settings or similar treatments.

''(c) IN- AND OUT-OF-NETWORK.—

''(1) IN GENERAL.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits, and that provides such benefits on both an in- and out-of-network basis pursuant to the terms of the plan (or coverage), such plan (or coverage) shall ensure that the requirements of this section are applied to both in- and out-of-network services by comparing in-network medical and surgical benefits to in-network mental health benefits and out-of-network medical and surgical benefits to out-of-network mental health benefits, except that in no event shall this subsection require the provision of out-of-network coverage for mental health benefits even in the case where out-of-network coverage is provided for medical and surgical benefits.

''(2) CLARIFICATION.—Nothing in paragraph (1) shall be construed as requiring that a group health plan (or coverage in connection with such a plan) eliminate an out-of-network provider option from such plan (or coverage) pursuant to the terms of the plan (or coverage).

''(d) SMALL EMPLOYER EXEMPTION.—

''(1) IN GENERAL.—This section shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year of any employer who employed an average of at least 2 (or 1 in the case of an employer residing in a State that permits small groups to include a single individual) but not more than 50 employees on business days during the preceding calendar year.

''(2) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of this subsection:

''(A) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—Rules similar to the rules under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code of 1986 shall apply for purposes of treating persons as a single employer.

''(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

''(C) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

''(e) COST EXEMPTION.—

''(1) IN GENERAL.—With respect to a group health plan (or health insurance coverage offered in connections with such a plan), if the application of this section to such plan (or coverage) results in an increase for the plan year involved of the actual total costs of coverage with respect to medical and surgical benefits and mental health benefits under the plan (as determined and certified under paragraph (3)) by an amount that exceeds the applicable percentage described in paragraph (2) of the actual total plan costs, the provisions of this section shall not apply to such plan (or coverage) during the fol-

lowing plan year, and such exemption shall apply to the plan (or coverage) for 1 plan year. An employer may elect to continue to apply mental health parity pursuant to this section with respect to the group health plan (or coverage) involved regardless of any increase in total costs.

''(2) APPLICABLE PERCENTAGE.—With respect to a plan (or coverage), the applicable percentage described in this paragraph shall be—

''(A) 2 percent in the case of the first plan year in which this section is applied; and

''(B) 1 percent in the case of each subsequent plan year.

''(3) DETERMINATIONS BY ACTUARIES.—Determinations as to increases in actual costs under a plan (or coverage) for purposes of this section shall be made by a qualified actuary who is a member in good standing of the American Academy of Actuaries. Such determinations shall be certified by the actuary and be made available to the general public.

''(4) 6-MONTH DETERMINATIONS.—If a group health plan (or a health insurance issuer offering coverage in connections with a group health plan) seeks an exemption under this subsection, determinations under paragraph (1) shall be made after

such plan (or coverage) has complied with this section for the first 6 months of the plan year involved.

''(5) NOTIFICATION.—An election to modify coverage of mental health benefits as permitted under this subsection shall be treated as a material modification in the terms of the plan as described in section 102(a)(1) and shall be subject to the applicable notice requirements under section 104(b)(1).

''(f) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to require a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits.

''(g) MENTAL HEALTH BENEFITS.—In this section, the term 'mental health benefits' means benefits with respect to mental health services (including substance abuse treatment) as defined under the terms of the group health plan or coverage, and when applicable as may be defined under State law when applicable to health insurance coverage offered in connection with a group health plan.''.

SEC. 3. EFFECTIVE DATE.

(a) IN GENERAL.—The provisions of this Act shall apply to group health plans (or health insurance coverage offered in connection with such plans) beginning in the first plan year that begins on or after January 1 of the

first calendar year that begins more than 1 year after the date of the enactment of this Act.

(b) TERMINATION OF CERTAIN PROVISIONS.—

(1) ERISA.—Section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a) is amended by striking subsection (f) and inserting the following:

''(f) SUNSET.—This section shall not apply to benefits for services furnished after the effective date described in section 3(a) of the Mental Health Parity Act of 2007.''.

(2) PHSA.—Section 2705 of the Public Health Service Act (42 U.S.C. 300gg–5) is amended by striking subsection (f) and inserting the following:

''(f) SUNSET.—This section shall not apply to benefits for services furnished after the effective date described in section 3(a) of the Mental Health Parity Act of 2007.''.

SEC. 4. SPECIAL PREEMPTION RULE.

(a) ERISA PREEMPTION.—Section 731 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191) is amended—

(1) by redesignating subsections (c) and (d) as subsections (e) and (f), respectively; and

(2) by inserting after subsection (b), the following:

''(c) SPECIAL RULE IN CASE OF MENTAL HEALTH PARITY REQUIREMENTS.—

''(1) IN GENERAL.—Notwithstanding any provision of section 514 to the contrary, the provisions of this part relating to a group health plan or a health insurance issuer offering coverage in connection with a group health plan shall supercede any provision of State law that establishes, implements, or continues in effect any standard or requirement which differs from the specific standards or requirements contained in subsections (a), (b), (c), or (e) of section 712A.

''(2) CLARIFICATIONS.—Nothing in this subsection shall be construed to preempt State insurance laws relating to the individual insurance market or to small employers (as such term is defined for purposes of section 712A(d)).''.

(b) PHSA PREEMPTION.—Section 2723 of the Public Health Service Act (42 U.S.C. 300gg–23) is amended—

(1) by redesignating subsections (c) and (d) as subsections (e) and (f), respectively; and

(2) by inserting after subsection (b), the following:

''(c) SPECIAL RULE IN CASE OF MENTAL HEALTH PARITY REQUIREMENTS.—

''(1) IN GENERAL.—Notwithstanding any provision of section 514 of the Employee Retirement Income Security Act of 1974 to the contrary, the provisions of this part relating to a group health plan or a health insurance issuer offering coverage in connection with a group health plan shall supercede any provisions of State law that establishes, implements, or continues in effect any standard or requirement which differs from the specific standards or requirements contained in subsections (a), (b), (c), or (e) of section 2705A.

''(2) CLARIFICATIONS.—Nothing in this subsection shall be construed to preempt State insurance laws relating to the individual insurance market or to small employers (as such term is defined for purposes of section 2705A(d)).''.

(c) EFFECTIVE DATE.—The provisions of this section shall take effect with respect to a State, on the date on which the provisions of section 2 apply with respect to group health plans and health insurance coverage offered in connection with group health plans.

SEC. 5. FEDERAL ADMINISTRATIVE RESPONSIBILITIES.

(a) GROUP HEALTH PLAN OMBUDSMAN.—

(1) DEPARTMENT OF LABOR.—The Secretary of Labor shall designate an individual within the De-

partment of Labor to serve as the group health plan ombudsman for the Department. Such ombudsman shall serve as an initial point of contact to permit individuals to obtain information and provide assistance concerning coverage of mental health services under group health plans in accordance with this Act.

(2) DEPARTMENT OF HEALTH AND HUMAN SERVICES.—The Secretary of Health and Human Services shall designate an individual within the Department of Health and Human Services to serve as the group health plan ombudsman for the Department. Such ombudsman shall serve as an initial point of contact to permit individuals to obtain information and provide assistance concerning coverage of mental health services under health insurance coverage issued in connection with group health plans in accordance with this Act.

(b) AUDITS.—The Secretary of Labor and the Secretary of Health and Human Services shall each provide for the conduct of random audits of group health plans (and health insurance coverage offered in connection with such plans) to ensure that such plans are in compliance with this Act (and the amendments made by this Act).

(c) GOVERNMENT ACCOUNTABILITY OFFICE STUDY.—

(1) STUDY.—The Comptroller General shall conduct a study that evaluates the effect of the implementation of the amendments made by this Act on the cost of health insurance coverage, access to health insurance coverage (including the availability of in-network providers), the quality of health care, the impact on benefits and coverage for mental health and substance abuse, the impact of any additional cost or savings to the plan, the impact on State mental health benefit mandate laws, other impact on the business community and the Federal Government, and other issues as determined appropriate by the Comptroller General.

(2) REPORT.—Not later than 2 years after the date of enactment of this Act, the Comptroller General shall prepare and submit to the appropriate committees of Congress a report containing the results of the study conducted under paragraph (1).

(d) REGULATIONS.—Not later than 1 year after the date of enactment of this Act, the Secretary of Labor and the Secretary of Health and Human Services shall jointly promulgate final regulations to carry out this Act.

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